A rare surgical case

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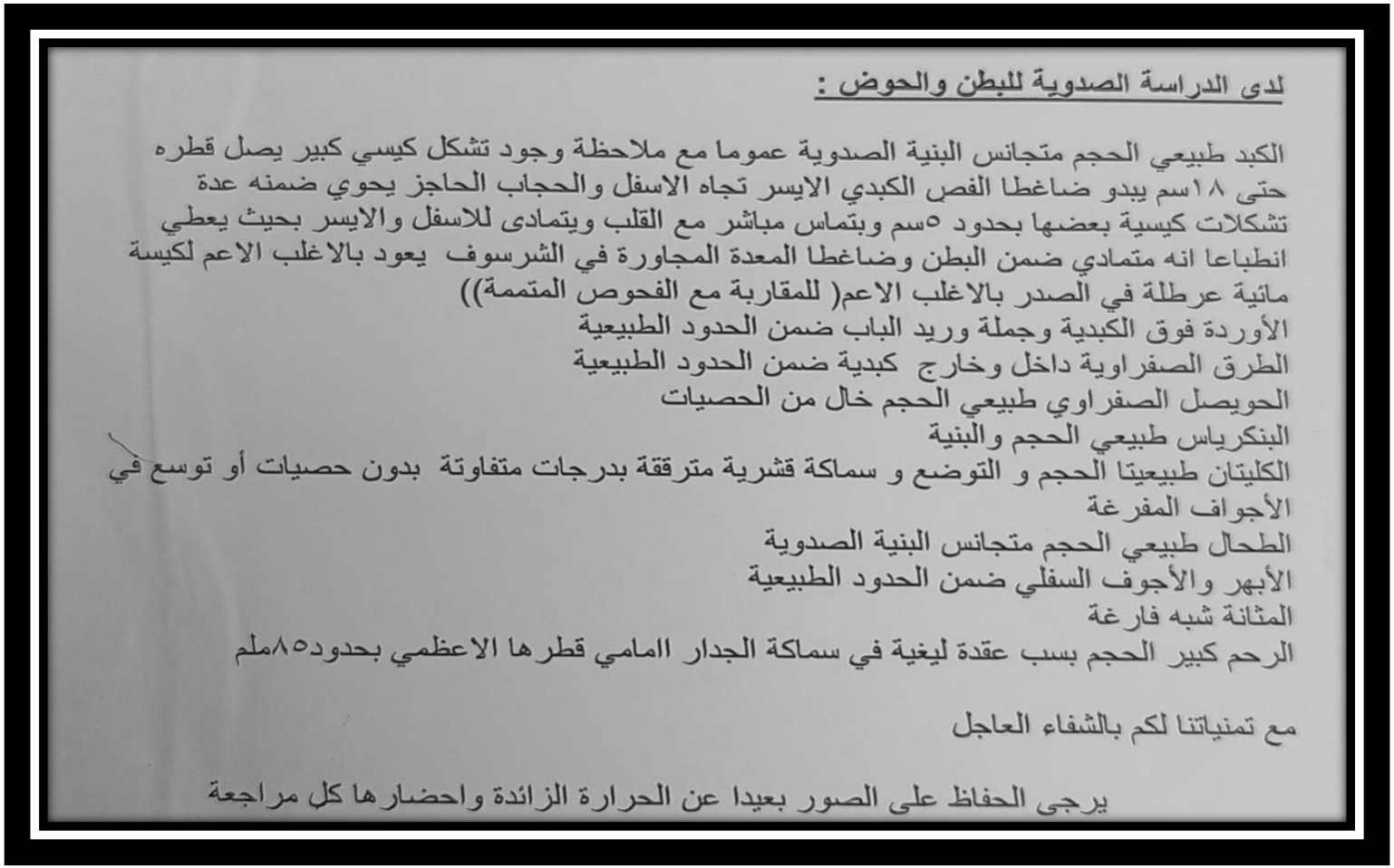
As a Clinical Case, A 62-year-old female patient presented to our thoracic surgery department due to repeated : attacks of chest pain, hiccups, intermittent coughing, general weakness, and bouts of fever

No significant history was reported.

On **physical examination**, the chest wall was symmetrical on both sides; there was no tenderness on palpation, and on auscultation there were : diminished respiratory sounds at the base of the left lung.

The abdominal echo showes an 18 cm cystic formation in the left hypochondrium, extending to the thoracic cavity, it is pressing on the left hepatic lobe and contains several cystic formations, The cyst has direct contact with the pericardium.



لدى الدراسة الصدوية للبطن والحوض :

الكبد طبيعي الحجم متجانس البنية الصدوية عموما مع ملاحظة وجود تشكل كيسي كبير يصل قطره حتى ١٨سم يبدو ضاغطا الفص الكبدي الايسر تجاه الاسفل والحجاب الحاجز يحوي ضمنه عدة تشكلات كيسية بعضها بحدود ٥سم وبتماس مباشر مع القلب ويتمادى للاسفل والايسر بحيث يعطي انطباعا انه متمادي ضمن البطن وضاغطا المعدة المجاورة في الشرسوف يعود بالاغلب الاعم لكيسة مائية عرطلة في الصدر بالاغلب الاعم(للمقاربة مع الفحوص المتممة))
الأوردة فوق الكبدية وجملة وريد الباب ضمن الحدود الطبيعية
الطرق الصفراوية داخل وخارج كبدية ضمن الحدود الطبيعية
الحويصل الصفراوي طبيعي الحجم خال من الحصيات
البنكرياس طبيعي الحجم والبنية
الكليتان طبيعيتا الحجم و التوضع و سماكة قشرية مترققة بدرجات متفاوتة بدون حصيات أو توسع في الأجواف المفرغة
الطحال طبيعي الحجم متجانس البنية الصدوية
الأبهر والأجوف السفلي ضمن الحدود الطبيعية
المثانة شبه فارغة
الرحم كبير الحجم بسب عقدة ليغية في سماكة الجدار امامي قطرها الاعظمي بحدود٨٥ملم

مع تمنياتنا لكم بالشفاء العاجل

يرجى الحفاظ على الصور بعيدا عن الحرارة الزائدة واحضارها كل مراجعة

تقرير الطبيب الأخصائي: كتلة ناقصة الكثافة مع تعزيز للمادة الظليلة غير متجانس

تتوضع في الجانب الأيسر للبطن تقيس حوالي ١٥ × ١٤ × ١٠ سم

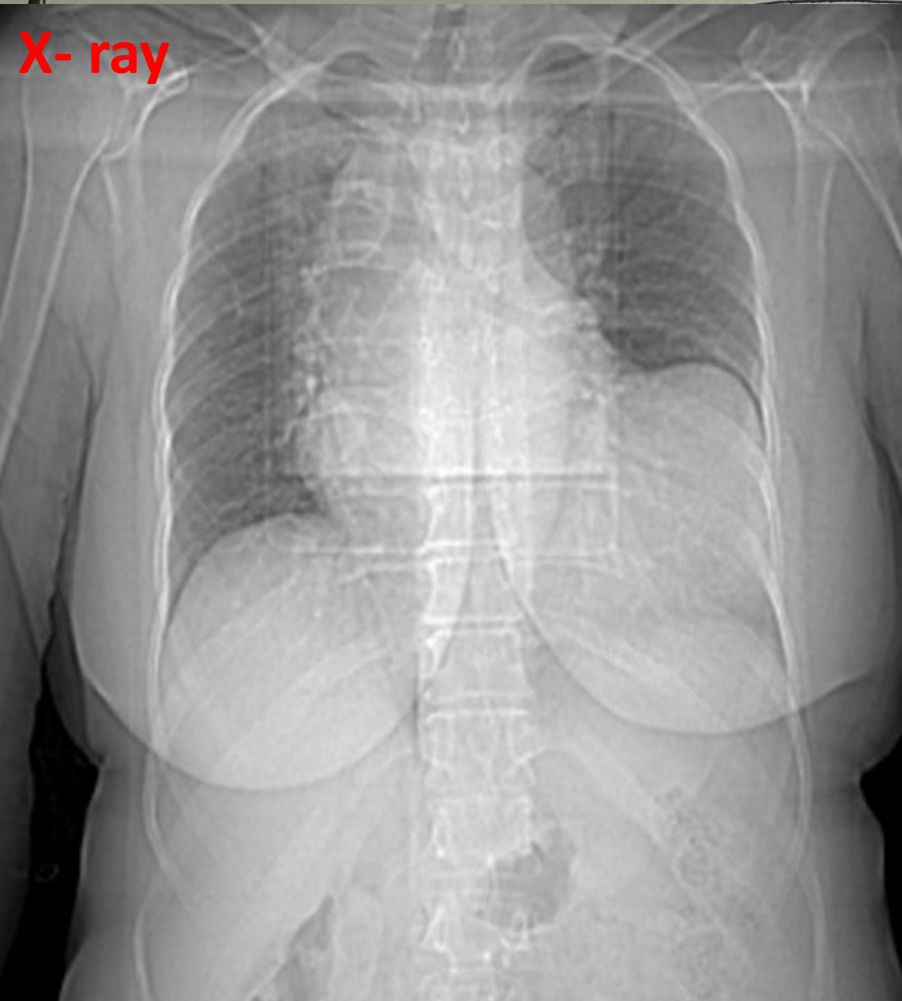
تتوضع بين الفص الأيسر الكبدي ، الطحال ، البنكرياس ، المعدة

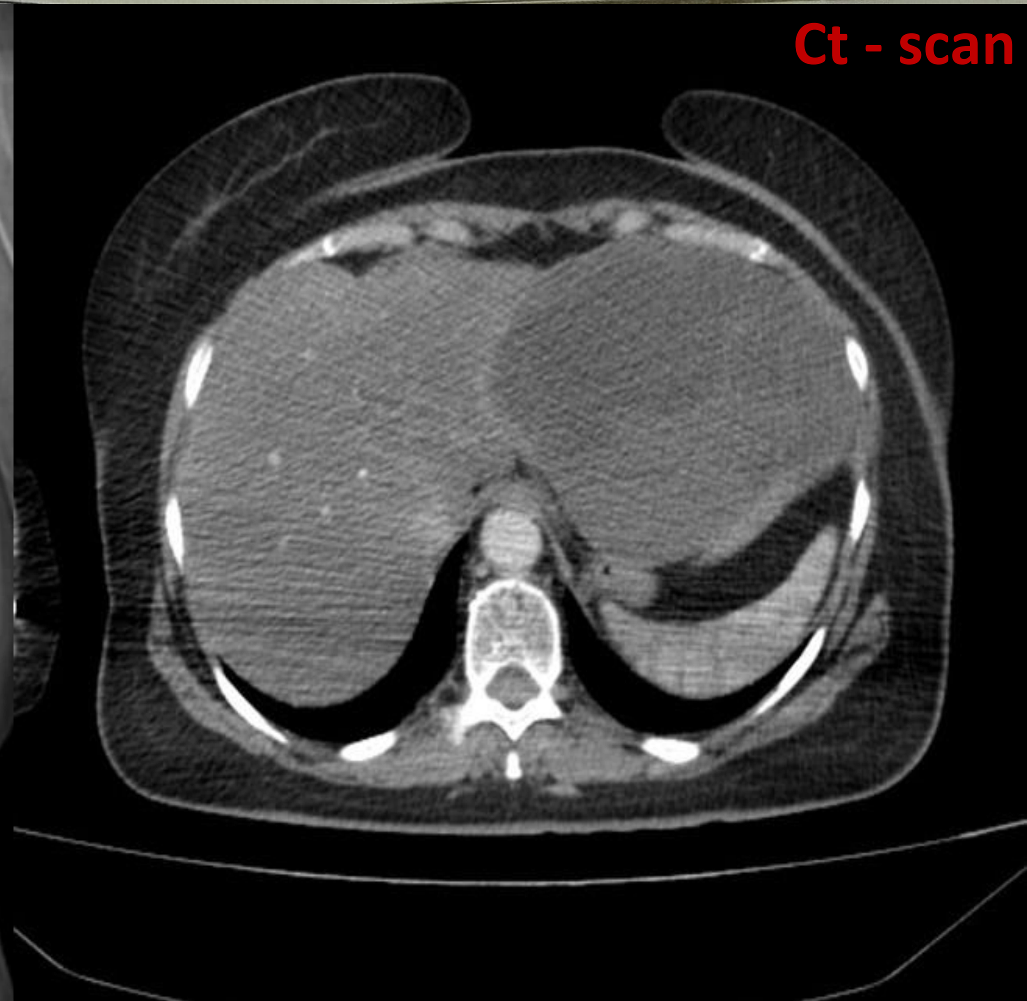
كتلة شبيهة صلبة ناقصة الكثافة في مستوى الرحم مع تعزيز ضعيف

للمادة الظليلة تقيس حوالي ٩ × ٨ × ٨ سم

كيسة كلية يسرى تقيس حوالي ١،٧ سم

فقد الوريدات الشعرية جانبية

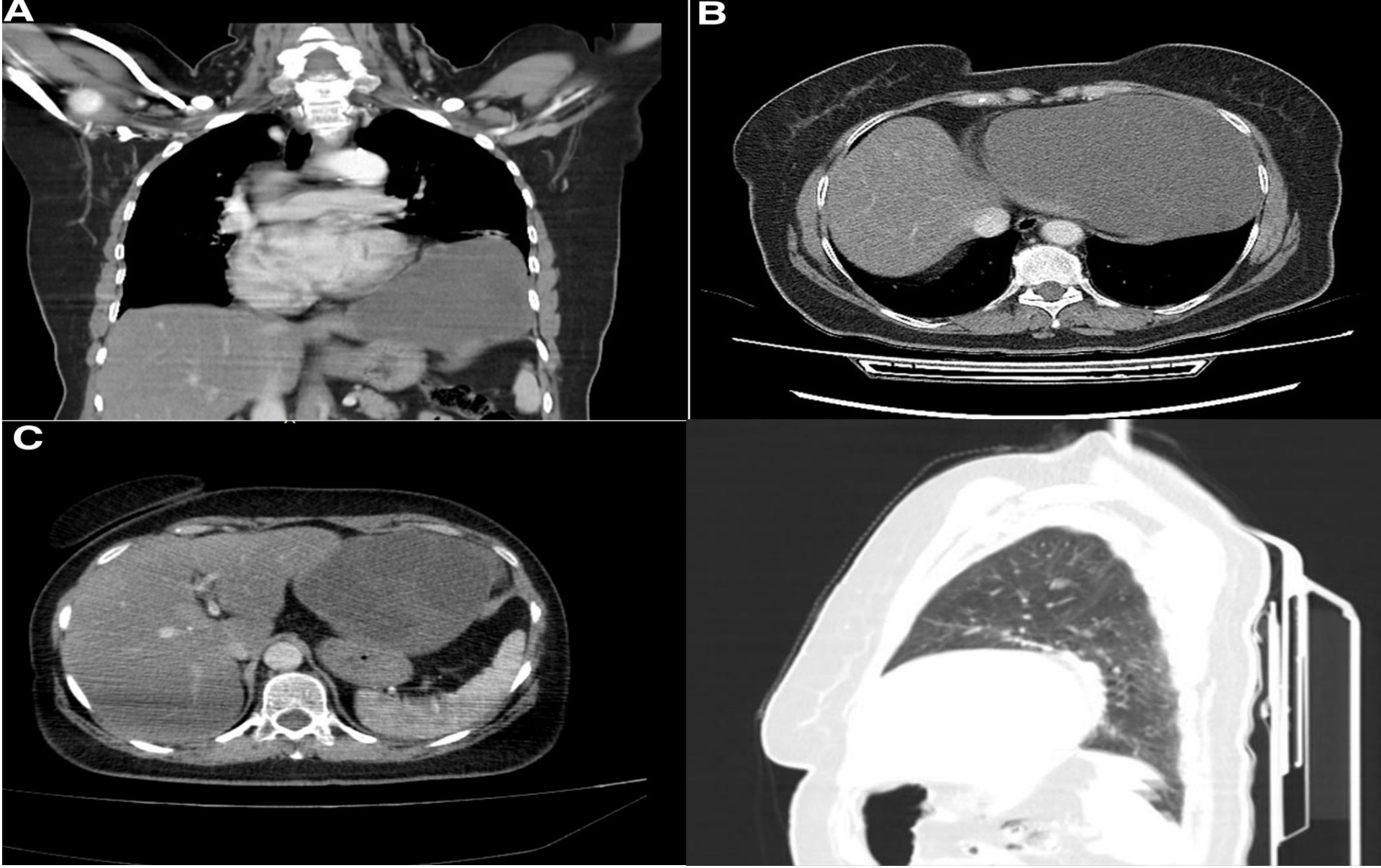




Our opinion was that it formed inside the chest cavity and that the CT reading was not accurate, and since the patient's brother is a gastroenterologist an investigative laparoscopy was performed to determine the relationship of the mass with the abdominal cavity .

The result of the labaroscopy was the peritoneum was domed toward the abdominal cavity, but it was intact .

Labs were normal , and the Echinococcus granulosus antibody test was negative (1/80), A multi-slice CT was repeated before surgery, as it showed :



Computed tomography (CT) scan showed a cystic formation containing varying densities. The cyst size was 15 × 13 × 12 cm with an COMPLEX location involving the left lower thorax and the left cardio phrenic angle, with a direct bordering of the pericardium and the left hepatic lobe.

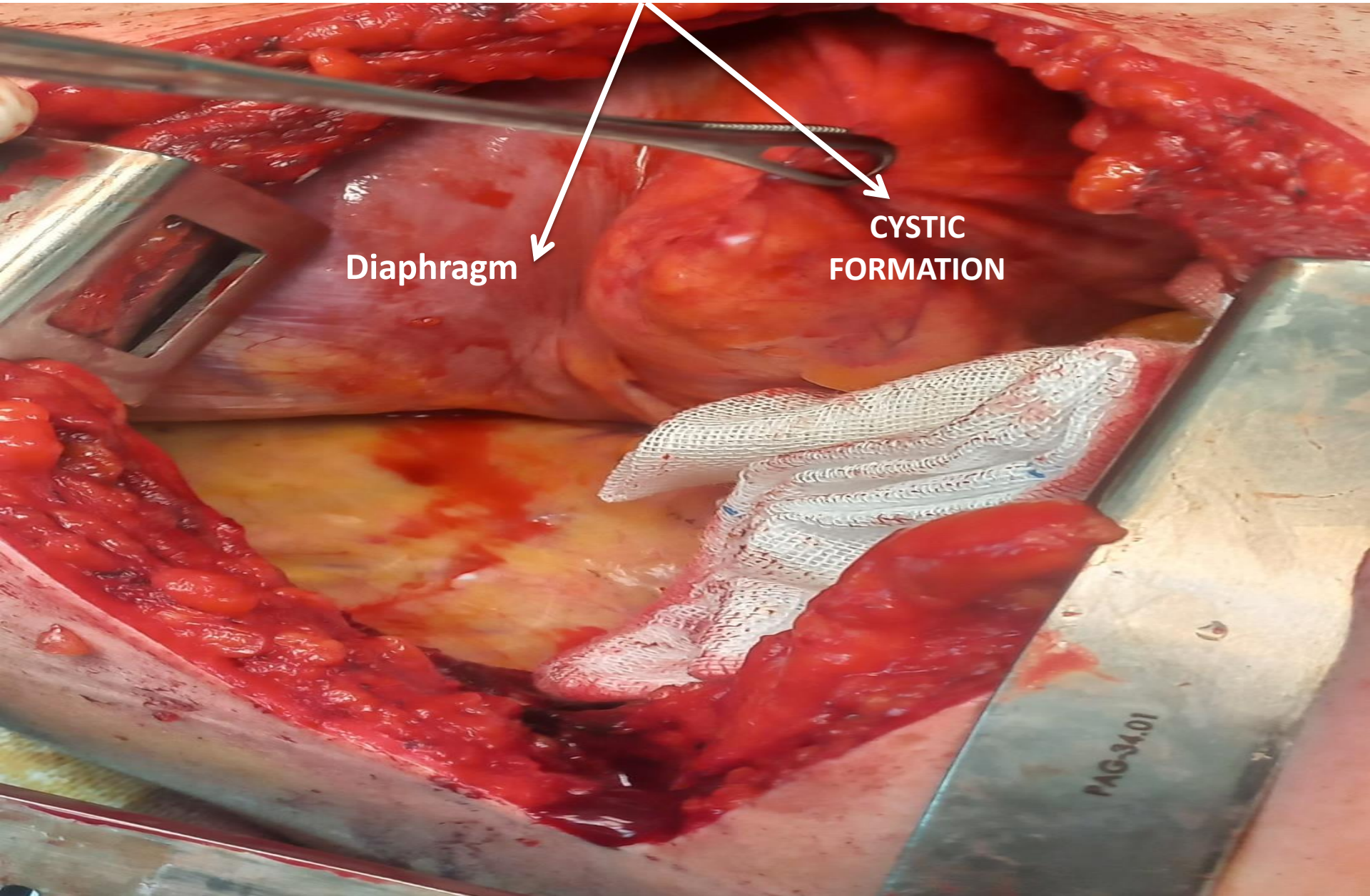
Differential diagnosis

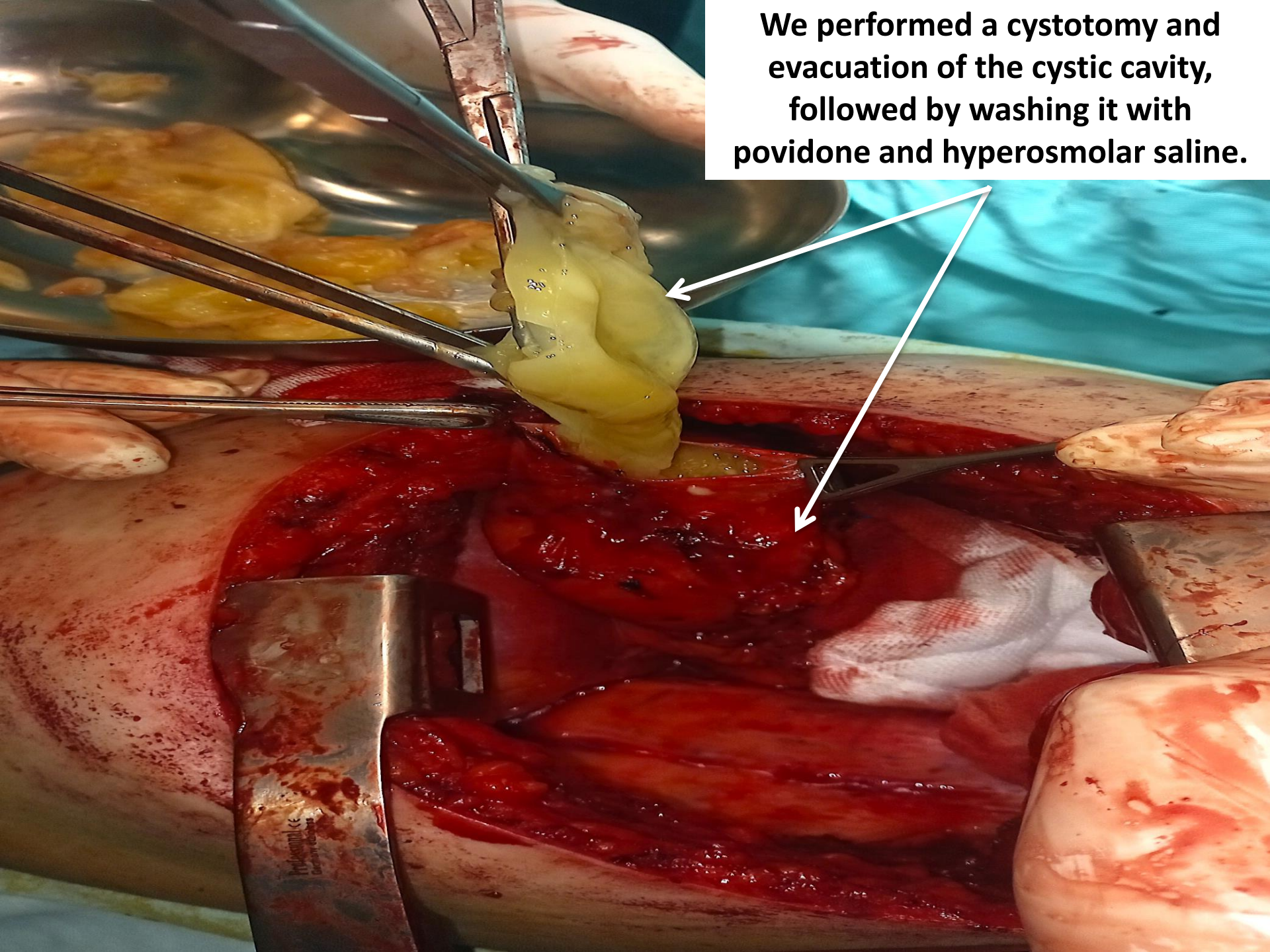
The top differential diagnosis was :

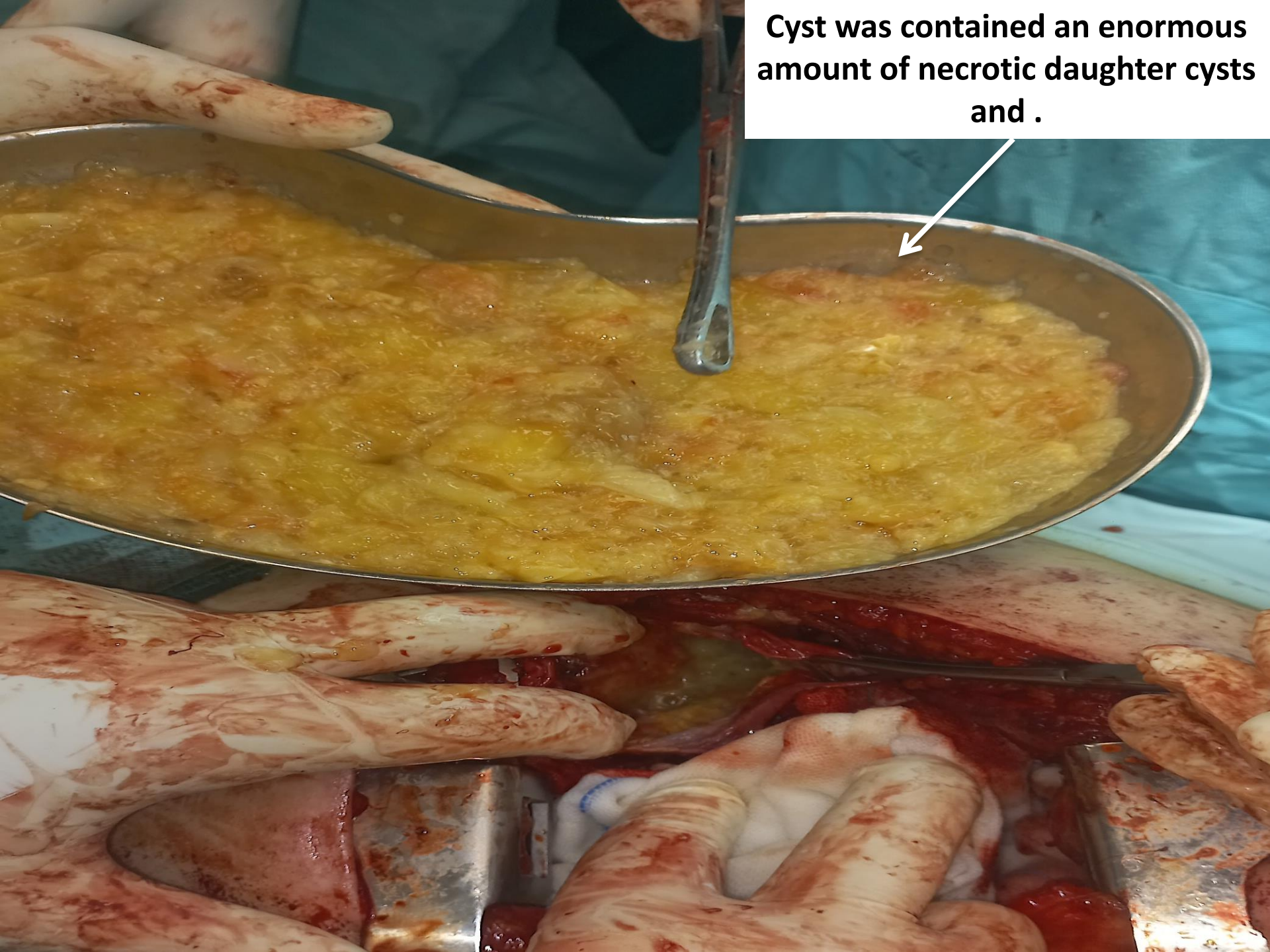
* Giant hydatid cyst, Teratoma
* Congenital diaphragmatic hernia
* Diaphragmatic neurenteric
* Neurentric duplication cysts

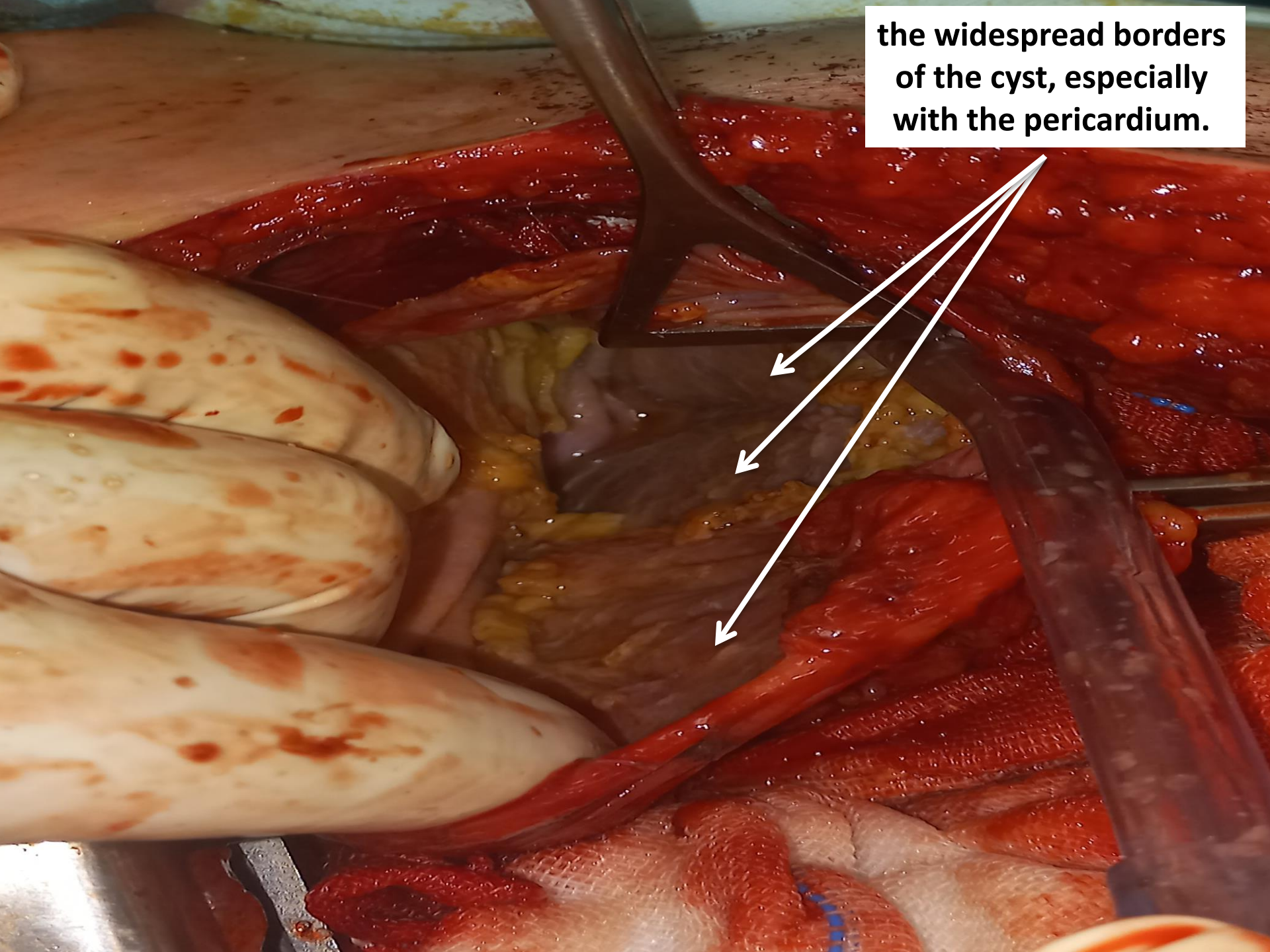
were put into consideration

The patient underwent a left posterolateral thoracotomy, Cystic formation was visualized in the left cardiophrenicangle, The cyst was embedded in the peripheral diaphragm, causing an eventration without penetrating the peritoneum.




We performed a cystotomy and evacuation of the cystic cavity, followed by washing it with povidone and hyperosmolar saline.

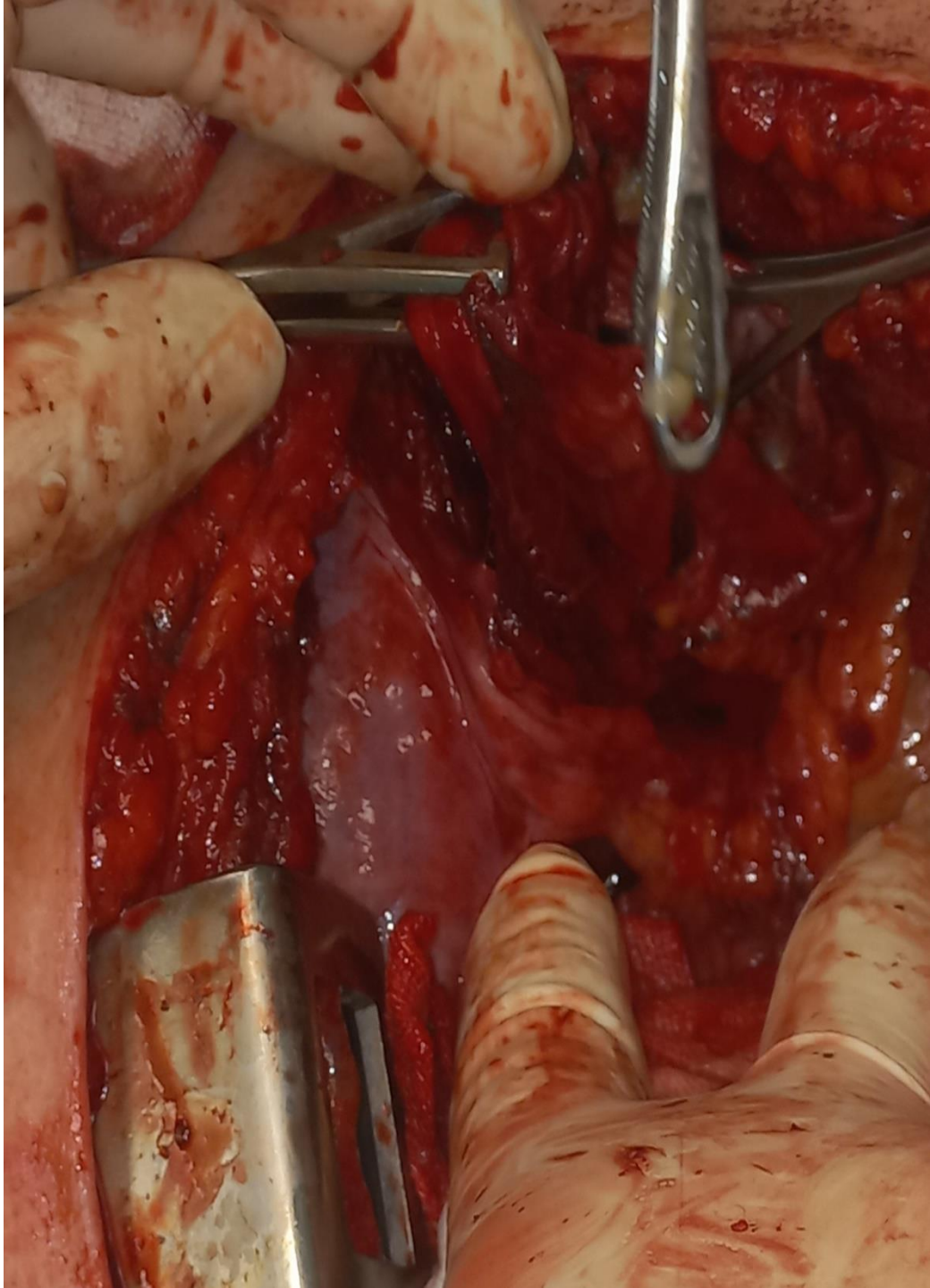

Cyst was contained an enormous amount of necrotic daughter cysts and .


the widespread borders of the cyst, especially with the pericardium.

The diaphragm defect was small, so it was closed <u>without</u> a mesh to repair the eventration.

Then, the diaphragm was sutured to the ribs to give it more stability.

Two drainages were put in the cyst and thoracic cavity.



Postoperative X-ray shows lung expansion, two drainages were put in the cyst and thoracic cavity.

PATHOLOGY REPORT

Diagnosis:

Lung cysts:

- Hydatid cysts (echinococcosis).
- No malignancy.

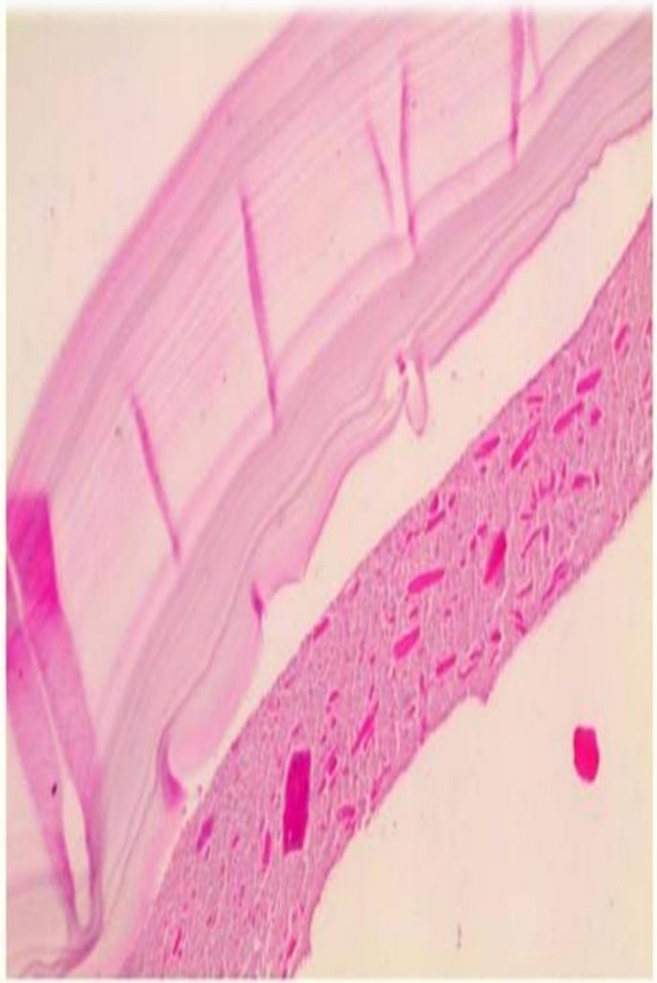
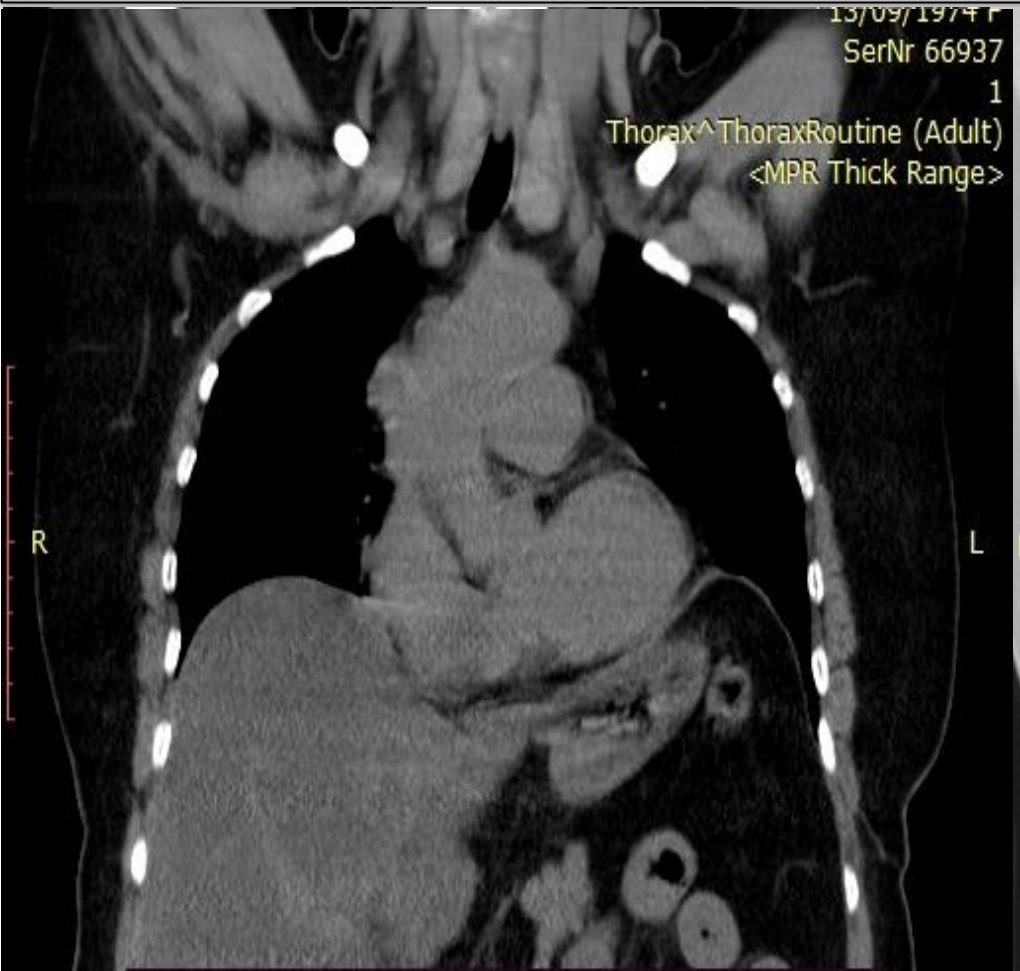


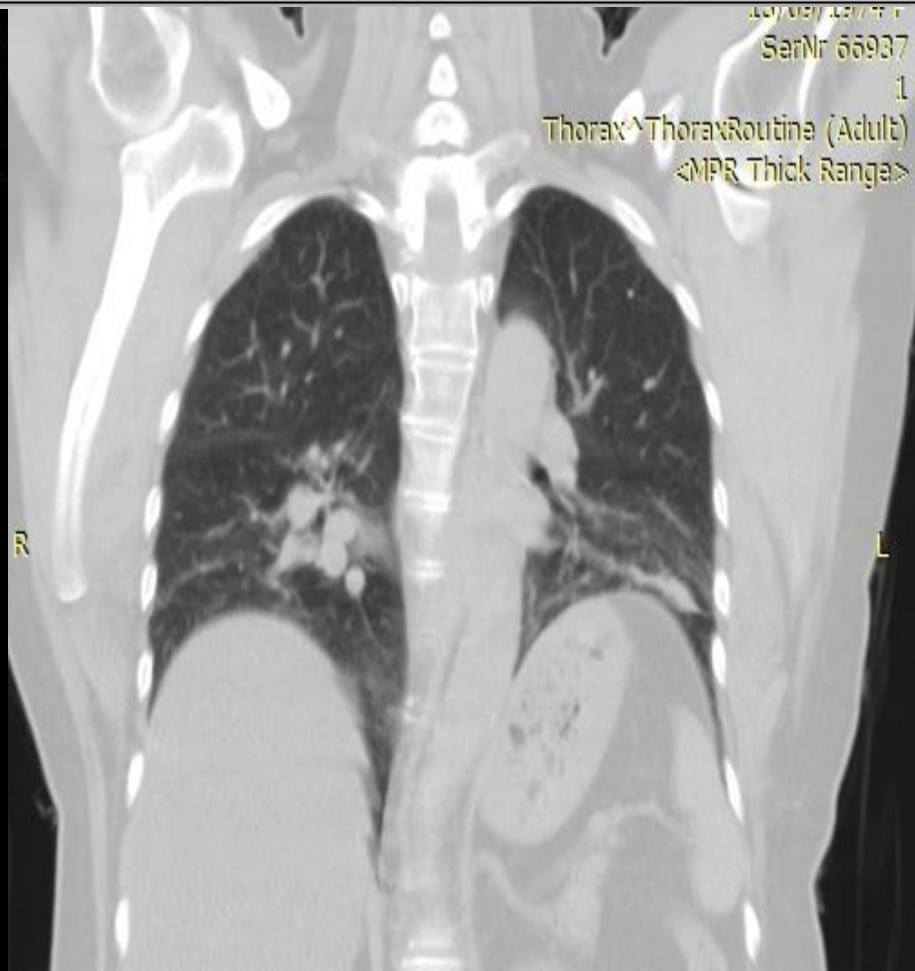
Figure 4. Histopathological examination: the cyst wall comprises an acellular laminated membrane and an inner nucleated germinal layer. Within the cystic cavity, necrotic debris is predominantly present. (Hematoxylin and eosin staining; 100× magnification.)

Albendazole 10 mg/kg was administered orally for 6 months postoperatively to avoid recurrence.

After 12 months of follow-up

no recurrence was observed.





Conclusions :

Intrathoracic extrapulmonary HCs causing eventration are very rare

To our knowledge, this is the first case report of a HC combining those two occurrences involving the left cardiophrenic angle.

Complete surgical resection is the standard treatment for HCs.

The main particularities of our case are: the location and borders of the cyst involving the left cardiophrenic angle and causing eventration of the diaphragm.

The appropriate surgical approach to HCs should be made based on many factors, such as the patient's status, the location, borders, and size, of the cyst.

HCs, especially in endemic areas, should always be a differential diagnosis for patients presenting with a cyst lesion in the thoracic cavity.

OXFORD

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Case Report

Case Report

Primary left intrathoracic extrapulmonary trans-diaphragmatic hydatid cyst causing eventration: first case in literature

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Abstract

Hydatidosis is a zoonotic parasitic disease caused by the cystic stage of Echinococcus species. Intrathoracic extrapulmonary hydatid cysts causing eventration are very rare. Here, we report a case of a 62-year-old female who presented with chest pain, intermittent coughing, general weakness, and fever. On auscultation, there were diminished respiratory sounds at the base of the left lung. A computed tomography scan showed a cystic formation with an ambiguous location involving the left lower thorax and the left hypochondrium. Complete surgical resection is the standard treatment for intrathoracic extrapulmonary hydatid cysts. Due to the direct bordering of the cyst with the pericardium in the left cadiophrenic angle, a cystotomy and evacuation of the cystic cavity were performed, followed by washing it with povidone and hyperosmolar saline. The location of the hydatid cyst has an important role in determining the surgical approach, as the unusual location could affect the possibility of radically removing the cyst.

Keywords: hydatid cyst; intrathoracic extrapulmonary hydatid cysts; case report

Introduction

Hydatidosis is a zoonotic parasitic disease caused by the cystic stage of *Echinococcus* species, which is commonly known as hydatid cyst (HC) [1]. Its prevalence is very high in the Mediterranean region [1, 2]. *Echinococcus granulosus* species is responsible for >95% of cases [2]. The most commonly affected organ is the liver, followed by the lungs [3]. Intrathoracic extrapulmonary HCs are very rare, with an occurrence rate of 7.4% of total thoracic HCs [4].

Here, we report a one-of-a-kind case of a primary left intrathoracic extrapulmonary trans-diaphragmatic HC causing eventration. To the best of our knowledge, this is the first case reported in the literature.

Case report

A 62-year-old female patient presented to our thoracic surgery department due to repeated attacks of chest pain, hiccups, intermittent coughing, general weakness, and bouts of fever. On physical examination, the chest wall was symmetrical on both sides; there was no tenderness on palpation, and on auscultation, there

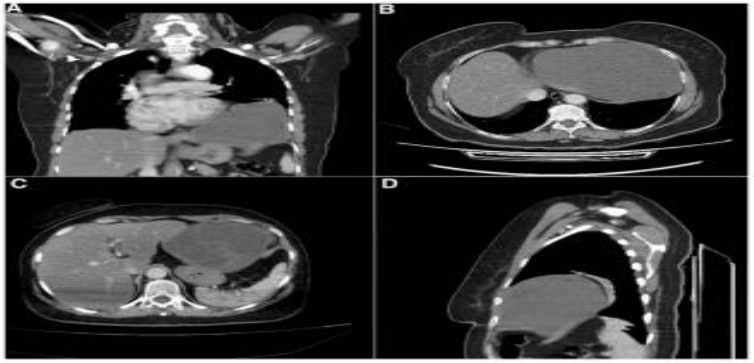

Figure 1. Computed tomography (CT) scan. (A) Coronal section, shows the cystic formation in the left hemi-thorax. (B) and (C) Axial section, shows the borders with the pericardium and the left hepatic lobe. (D) Sagittal section, shows the limited posterior extension of the cyst.

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RARE SURGICAL CASES PUBLISHED IN INTERNATIONAL JOURNALS

FROM DEPARTMENT OF THORACIC SURGERY

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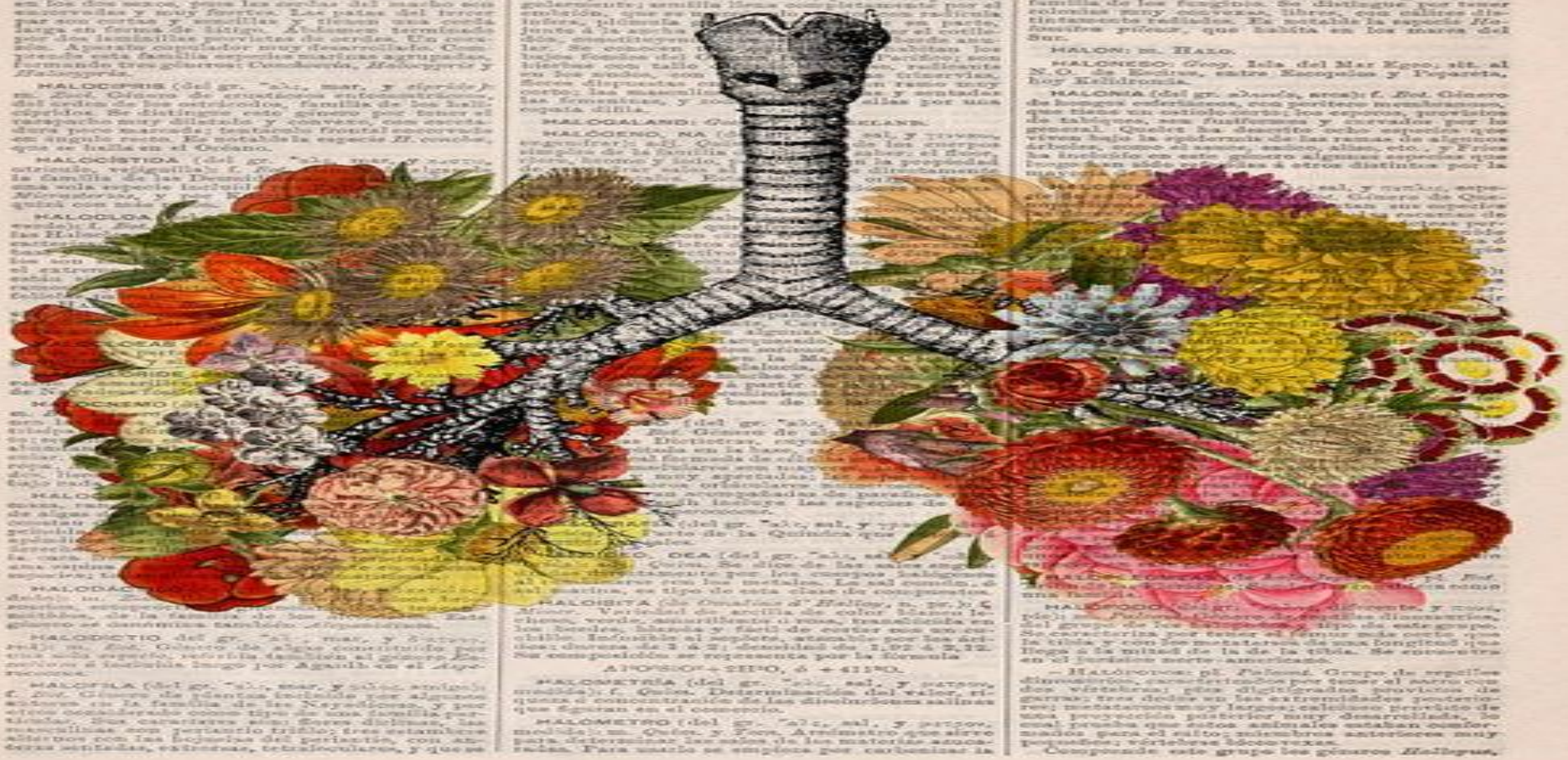

Case Reports > Respir Med Case Rep. 2024 Jun 5:50:102065. doi: 10.1016/j.rmcr.2024.102065. eCollection 2024.

Xanthogranulomatous pleuritis induced by recurrent biliothorax due to a biliopleural fistula: The first case report in the literature

Moatasem Hussein Al-Janabi [1], Hussein Kaada [2], Ghina Ismail [3], Dommar Roumieh [2], Zuheir Al-Shehabi [1]

Affiliations + expand

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Abstract

Xanthogranulomatous pleuritis is an extremely rare pathological entity, characterized by the infiltration of foamy cells and multinucleated giant cells within the pleural space. This condition often mimics infectious and neoplastic processes, presenting significant diagnostic challenges. This report details the first documented case of xanthogranulomatous pleuritis induced by recurrent biliothorax due to a biliopleural fistula, presenting a unique clinical scenario. We describe the clinical presentation, diagnostic hurdles, and both the surgical and medical management of this case. The discovery of biliothorax, evidenced by pleural fluid bilirubin levels that exceed serum bilirubin levels, underscores the importance of considering biliothorax in the differential diagnosis of recurrent pleural effusions, particularly in patients with a history of trauma. This case emphasizes the need for heightened awareness and a multidisciplinary approach in the diagnosis and treatment to effectively manage this complex condition and prevent recurrence.

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Surgical Case Report

INTERNATIONAL JOURNAL OF SURGERY OPEN

OPEN

Swift growing bursitis secondary to osteochondroma in the left scapula causing pseudo-winging: a rare case report

Hussein Kaada, MD[a], George Bashour[b,c,*], Saddik Haddad[b,c], Sulman Alkadi, MD, PhD[a], Mariam Sharbo, BSc[b], Moatasem Hussein Al-janabi, MD[d], Rana Issa, MD[d]

Introduction: Osteochondroma is a common benign bone tumor, but it is unusual to develop in flat bones such as the scapula. Furthermore, the formation of bursae is one of the rare complications of osteochondroma and it can be mistaken for a malignant transformation. Bursa formation can manifest clinically as an enlarging mass overlying an osteochondroma. This enlarging mass could be a rare cause of scapular winging by mass effect, which is called pseudo-winging.

Presentation: Here, we present a case of a 29-year-old female presented with a painful mass on the left posterior chest wall. Clinical examination showed winging of the scapula, but the neuromotor examination was normal. Computed tomography scan showed an osteoid mass with a large cyst on the ventral side of the scapula. A surgical resection was performed, and the malignant transformation was histologically ruled out.

Clinical discussion: The final diagnosis was osteochondroma with bursitis causing pseudo-winging. Careful clinical examination should be done to differentiate between true and pseudo-winging. The diagnostic challenge in our case was the clinical distinction between malignant transformation of osteochondroma and benign lesion. Patients with pseudo-winging can be treated with surgical removal of the bursa, and this type of winging requires only short-term physical therapy.

Conclusion: Bursitis secondary to osteochondroma on the ventral surface of the scapula should be considered as a differential diagnosis for a rapidly growing mass. Surgical resection is the treatment of choice.

Keywords: bursitis, pseudo-winging, scapular osteochondroma

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Mature mediastinal teratoma with adhesions to the pericardium: A rare case report

ONCOLOGY SURGERY

Somar Mansour, Ali Badr, Majd Mansour, Mouhamad Badr, Ali Afif, Samer Rajab, Zuheir Al-Shehabi

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DOI: 10.22541/au.172143369.91391900/v1

Introduction:

Mature teratomas are subtypes of germ cell tumors that contain tissues from endodermal, mesodermal, and ectodermal germ cell layers**[1]** . These tumors typically arise from gonads. Mature teratomas in the mediastinum are rare lesions; they are typically detected in the anterior mediastinum which is the most common location of extragonadal germ cell tumors **[1, 2]** . In addition, most teratoma tumors in the anterior mediastinum arise from the thymus or near thymus parenchyma, and intrapericardial or pericardial arising teratomas are considered extremely rare **[2]**

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CASE REPORT

Clinical Case Reports Open Access WILEY

Large tumoral pseudoangiomatous stromal hyperplasia with ER/PR stromal negativity in a 20-year-old female: A rare case report

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Key Clinical Message

Pseudoangiomatous stromal hyperplasia (PASH) is a rare lesion of the breast stromal tissue with unknown mechanism. Hormonal stimulation of mammary myofibroblasts is the most important theory due to stromal positivity of progesterone receptor (PR) or/and estrogen receptor (ER). We report a case of PASH with stromal PR/ER negativity.

KEYWORDS

breast tumor, case report, gigantomastia, pseudoangiomatous, stromal hyperplasia

1 | INTRODUCTION

Pseudoangiomatous stromal hyperplasia (PASH) is a rare, proliferative, benign breast lesion that was first described in 1986 by Raza et al.[1]

It most commonly occurs during the premenopausal period and is often found incidentally in breast biopsy, but it can occasionally grow in some cases to form an extremely large mass.[2] It has a physical and psychological cases. The treatment depends on the size of the mass and surgical procedure is the gold standard treatment in large symptomatic cases.[3]

Herein, we report a rare case of PASH with negative stromal PR/ER expression and was developed during adolescence.

2 | PRESENTATION

http://dx.doi.org/10.1002/ccr3.8398

Thanks for your kind attention